Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: PHI Air Medical PO Box 60557 Los Angeles, CA 90060	MFDR Tracking #: M4-08-3419-01 DWC Claim Injured Employ Date of Inju
Respondent Name and Box #: Ace American Insurance Co Box #: 15	Employer Nam Insurance Carrier

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary, as taken from the Table of Disputed Services states in part, "...Not paid per 2007 TWCC guidelines..."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $2,362.62
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "...Explanation of review attached. No record of reconsideration request received by Coventry (bill review)..."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	HCPCS Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
9/11/07	A0431-SH ($5,366.30=MAR-$3,577.53)	W1, 663	1-4	$1,788.77
9/11/07	A0436-SH ($1,721.55=MAR-$1,147.70)	W1, 663	1-4	$573.85
Total Due:				$2,362.62

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines,* and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code:
   - "W1 – Workers Compensation State Fee Schedule adjustment
   - Reimbursement has been calculated according to state fee schedule guidelines."

2. The Respondent did not reimburse the Requestor the correct allowable amount. The reimbursement is as follows:
   - HCPCS code A0431-SH the MAR is $5,366.30($4,293.04 x 125%)
   - $5,366.30(MAR) - $3,577.53(Carrier Paid) = $1,788.77
   - HCPCS code A0436-SH the MAR is $1,721.55($29.94 x 46 miles x 125%)
   - $1,721.55(MAR) - $1,147.70(Carrier Paid) = $573.85
3. Therefore, according to Rule 134.202(c)(2), additional reimbursement is recommended.
4. Per review of Box 32 on CMS-1500, zip code 77575 is considered a Rural Area, in locality 99; therefore, the Rural Base Rate & Rural Mileage Rate applies. The maximum reimbursement amount, under Rule 134.202(b) & (c)(2), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $2,362.62 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORI [redacted] [redacted] 5/9/2008

Authorized Signature | Medical Fee Dispute Resolution Officer | Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.